



PROGRAMMATIC GUIDANCE FOR SEXUAL AND REPRODUCTIVE HEALTH IN HUMANITARIAN AND FRAGILE SETTINGS DURING THE COVID-19 PANDEMIC

GOAL



Maintenance of essential preventive, promotive, and curative sexual and reproductive health services in fragile and humanitarian settings during the COVID-19 epidemic threat and outbreak period

OBJECTIVE



Provide programmatic guidance for decision making on sexual and reproductive health, including maternal and newborn health services, in fragile and humanitarian settings in the face of threat or reality of COVID-19



FOCUS

Fragile and humanitarian settings

This guidance was current as of early April 2020, but is subject to change as we gain more knowledge and experience in addressing COVID-19 and ensuring continuity of essential health services during this pandemic. Please check for updates and continue to share relevant experience.

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GENERAL GUIDANCE

Experience in past epidemics has shown that lack of access to essential health services and shut down of services unrelated to the epidemic response resulted in more deaths than those caused by the epidemic itself.¹

As the world tackles the COVID-19 pandemic, it is important to ensure that essential health services and operations continue to address the sexual and reproductive health (SRH) needs and rights of people living in humanitarian and fragile settings.

- First and foremost, with the understanding that the risks of adverse outcomes from medical complications outweigh the potential risks of COVID-19 transmission at health facilities, **the availability of all critical services and supplies as defined by the Minimum Initial Services Package (MISP) for SRH must continue.** This includes intrapartum care for all births, emergency obstetric and newborn care, post-abortion care, safe abortion care to the full extent of the law, contraception, clinical care for rape survivors, and prevention and treatment for HIV and other sexually-transmitted infections. A lead SRH organization should be identified to coordinate implementation of the MISP for SRH and to plan for comprehensive sexual and reproductive health services if not already in place. It is essential that SRH coordination is integrated with the broader pandemic response coordination.
- **Comprehensive sexual and reproductive health services should be maintained as long as the system is not overstretched with COVID-19 case management.** This includes all antenatal care, postnatal care, newborn care, breastfeeding support, family planning and contraception services, cervical cancer screening, and care for those experiencing intimate partner violence. These services should stay available to all who need them, including adolescents and other often marginalized populations such as people with disabilities, for as long as possible.

Reductions or modification in routine services should only be considered to (1) ensure support to the epidemic response and COVID-19 case management and/or (2) to avert undue exposure to risk of contracting the virus in a health facility during an epidemic outbreak and/or when community transmission has been confirmed. A lead SRH agency should be identified to coordinate all actors and plan to reestablish comprehensive services as soon as possible.

¹ Health-Care Access during the Ebola Virus Epidemic in Liberia. 2017 Sep 7. ASTMA available [here](#).

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CONTINUATION OF SEXUAL & REPRODUCTIVE HEALTH (SRH) SERVICES

This guidance assumes that MISP or comprehensive sexual and reproductive health services are in place. It is designed to assist stakeholders faced with difficult decisions on when and how to scaleback comprehensive services or modify service delivery modality for select components of the MISP as part of COVID-19 mitigation and response measures. It is important to note that MISP services must continue uninterrupted regardless of context.²

2.1 Facility-based MISP services

► Access to **skilled birth attendance** and **emergency obstetric and newborn care** for all births is among the most essential services and needs to be ensured for all women and girls in need and their newborns. Care for the mother-newborn dyad should extend to 24 hours after birth.

- Women with high-risk conditions or warning signs of complications during pregnancy (e.g., bleeding, preterm labor) need to have access to skilled care 24/7. Post-abortion complications are considered obstetric emergencies and access to care must be maintained 24/7.

- Ensure access to treatment and medication for all pregnant women with chronic conditions in need of continuous treatment, particularly access to antiretrovirals as well as medications for hypertension and diabetes.

- Assess women presenting for intrapartum care, and adjust personal protective equipment and infection prevention and control measures accordingly. Ensure facilities have supplies and protocols to ensure appropriate isolation of pregnant women and mothers/newborns who have confirmed COVID-19 and/or develop systems.

- Cesarean surgeries should only be performed when medically indicated. COVID-19 positive status is NOT an indication for cesarean section.

- Continue to promote early and exclusive breastfeeding and skin-to-skin contact. In cases of suspected or confirmed COVID-19 infections, do not separate mother and newborn unless the one or both are critically ill.

- For more specific guidance on the management of pregnant and postpartum women with severe acute respiratory infection (SARI) in relation to COVID-19, consult the following documents:

- [WHO Interim Guidance on Clinical Management of Severe Acute Respiratory Infection when Novel Coronavirus \(nCoV\) is Suspected](#)
- [RCOG Information for Healthcare Professionals on Coronavirus \(COVID-19\) Infection in Pregnancy](#)

► **Prevention of unintended pregnancy** (refer for detailed guidance to “contraception” and “safe abortion care” in section 2.2)

► **Clinical care for rape survivors** is an emergency health service and access to care needs to be maintained 24/7. If restrictions need to be made, focus on the provision of first-line support using the WHO LIVES steps for all survivors,³ and for those who reach facilities within the first 72-120 hours, including post-exposure prophylaxis for HIV and emergency contraception, as well as wound care, tetanus vaccination when relevant. Reconvene with the patient at a later stage for complete vaccination, STI treatment, further medical examination and certificate.

► **Standard precautions and HIV prevention measures**, including safe and rational use of blood transfusion and provision of antiretrovirals to continue treatment for people who were enrolled in an anti-retroviral therapy program prior to the emergency, including women who were enrolled in programs to prevent vertical transmission. Provide post-exposure prophylaxis to survivors of sexual violence as appropriate and for occupational exposure.

² The Interagency Field Manual for Reproductive Health in Humanitarian Settings offers guidance for providing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in the initial phases of an emergency response, and comprehensive sexual and reproductive health services in established and protracted humanitarian responses.

³ WHO. *Clinical management of rape and intimate partner violence survivors – Developing protocols for use in humanitarian settings.*

2.2 | Alternative approaches to MISP and additional SRH services

Where feasible, consider remote approaches (telephone, digital applications, SMS text messaging, voice calls, interactive voice response) for relevant consultations, follow-up or screening.

► **Access to contraceptives is part of the MISP and needs to be maintained; alternatives to facility-based visits should be considered where possible.**

- Continue to offer a range of long-acting reversible and short-acting contraceptive methods at service delivery points including emergency contraception and post-pregnancy contraception.
- If restrictions need to be made, focus on providing continuity of contraceptive coverage, optimize access through community health systems, and remote counseling, provide supply for several months, and shift to self-management when possible.

► **Access to safe abortion to the full extent of the law is part of the MISP and needs to be maintained.**

- Ensure support for self-management of medical abortion up until 12 weeks to improve access to care, remote approaches can be considered for counseling on self-management.
- Continue to offer a range of options for post-pregnancy contraception.

► **Antenatal care (ANC)**

- Consider ANC clinic visits to the minimum required and advise women with low-risk pregnancies to postpone clinic visits during early pregnancy for a few weeks. Women with ANC complications need to have access to care 24/7.
- Prioritize routine visits for women in the third trimester and high-risk pregnancies.
- Consider redistribution of facility-level staff to provide ANC in the community following standard infection prevention and control precautions, and remote counseling and screening where feasible. Note: Community-based intrapartum care is not recommended, with the exception of settings where community-based midwives are linked to facilities, authorized, and fully equipped to attend home births.

► **Postnatal care (PNC) is critical for reducing preventable mortality and should be maintained.**

- Ensure access to PNC within 24 hours post-partum for women who left the maternity early after delivery or delivered at home.
- If restrictions need to be made, focus on first-week post-natal visits for women and newborns, including breastfeeding support
- Where a community health care system exists, community health workers following standard precautions can support basic antenatal and postnatal care at clients' homes. Remote counseling and screening for danger signs should also be considered where feasible.

⁴ WHO *Consolidated Guidelines on Self-Care interventions for Health. SRH. 2019.*

⁵ WHO *Telehealth (website).*

► **Syndromic management of sexually-transmitted infections is part of the MISP** and needs to be maintained, including presumptive treatment based on risk criteria (e.g., for survivors of sexual violence, treatment of partners of STI clients, sex workers etc.). Where capacity exists, syndromic diagnosis may be provided via telehealth.

► **Health workers should be prepared to care for those subjected to intimate partner violence**, as violence is likely to increase during epidemic outbreaks due to stress, increased confinement and exposure to perpetrators and reduced access to basic needs. Anyone who discloses intimate partner violence or comes to the attention of health workers for medical treatment related to violence, should be at minimum be offered first-line support using WHO LIVES job aid.

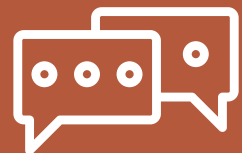
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INFORMATION & EDUCATION

► Ensure clear, consistent **public health messaging.**

- Reaffirm that medical complications outweigh the potential risk of transmission at health facilities. Community members should continue to seek and receive care during childbirth, and for all emergencies resulting from other diseases, trauma, or violence.
- Ensure understanding that any potential modifications of routine services are for patient benefit ⁽¹⁾ to ensure support to the epidemic response and ⁽²⁾ to avert undue exposure to risk of contracting the virus in a health facility during an epidemic outbreak.

► Ensure that **women, girls and SRH service providers are given evidence-based information** on keeping themselves and their families healthy and to allay fears, counteract rumors and correct misperceptions. Where possible, disseminate simple health education materials with key messages such as handwashing. Also consider pictorial versions for illiterate women and health workers.



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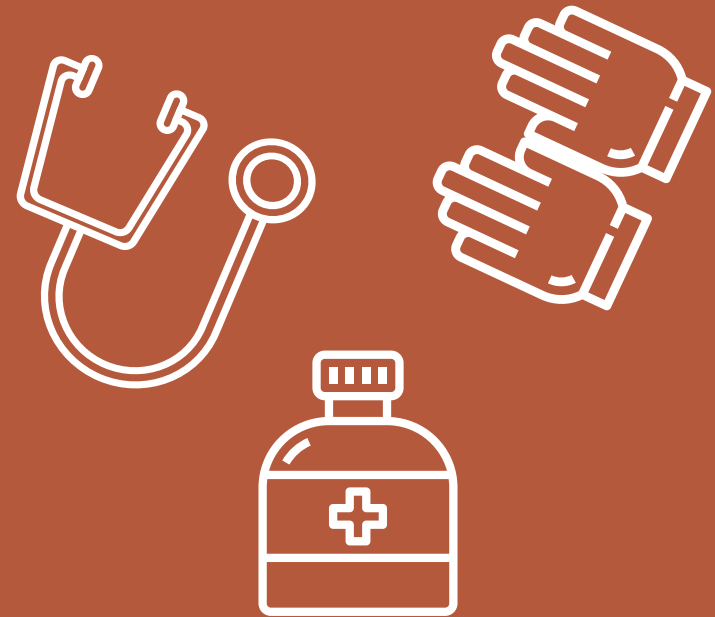
INFECTION PREVENTION & CONTROL

Infection prevention and control precautions apply for staff, patients, and accompanying family members at health facilities. Establish a patient flow that includes triage before entrance into the health facility and an isolation area that patients with COVID-19 symptoms can be escorted to. See guidance [here](#).

Where applicable, ensure facility and health worker readiness for inpatient obstetric care. Every effort should be made to minimize overcrowding of maternity wards to reduce the risk of healthcare-associated infections.

- ▶ **Develop/adapt protocols for the management of COVID-19 in pregnancy** including labor and birth in line with national protocols. In the absence of obstetric complications or risk factors consideration could be given to advising women to stay at home for early labor if limitation of contacts is feasible (complete self-isolation is not advised for laboring women).
- ▶ Intrapartum care of women with suspected or confirmed COVID-19 needs to ensure (1) isolation of the patient from other patients and (2) PPE (mask, goggles, gloves, gown/apron) for relevant health staff; the number of staff in contact with the woman should be reduced to a minimum ensuring capacity to deal with both maternal and potential neonatal complications.
- ▶ The benefits of **breastfeeding, early and uninterrupted skin-to-skin contact, prolonged kangaroo mother care**, and enabling mothers and infants to remain together in the same room throughout the day and night outweighs the potential risks of SARS-Cov-2 transmission. The following precautions should be taken for **mothers with suspected or confirmed COVID-19 infection**:
 - wear a mask when holding a child
 - wash hands before and after contact with her child
 - clean/disinfect surfaces she has been in contact with
 If a mother is **too ill to breastfeed**, she should be encouraged to express milk that can be given to the child by cup or spoon.
- ▶ The design and provision of **temporary facilities** should consider **the needs of mothers and newborns** including adequate space for breastfeeding, kangaroo mother care, and management of sick newborns.

Appropriate infection prevention and control precautions must also be taken for any community-level service provision. See [IASC Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings](#) for additional context-specific infection prevention and control and protection consideration.



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RESOURCES



Guidance documents

1. [IASC Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings](#). This document, jointly developed by IFRC, IOM, UNHCR and WHO, gives general COVID-19 programmatic preparedness and response guidance, and is specific to humanitarian settings.
2. [WHO Clinical management of severe acute respiratory infection \(SARI\) when COVID-19 disease is suspected. Interim guidance. 13 March 2020](#). The guide includes considerations for pregnant women and newborns through the document, and specific guidance on pregnancy, delivery and newborn care in chapters 12 and 13.
3. [WHO Infection Prevention and Control During Health Care When Novel Coronavirus \(nCOV\) Infection is Suspected](#). This guidance document is not specific to sexual and reproductive health services, but provides practical guidance for infection prevention and control at health facilities.
4. [WHO operational guidance on maintaining essential services during an outbreak. March 2020](#). This guidance document outlines steps to achieve universal access to quality care.
5. [WHO Q&A on COVID-19, pregnancy, childbirth and breastfeeding. 18 March 2020](#). This site provides answers to frequently asked questions on COVID-19, pregnancy, childbirth and breastfeeding, as well as links to related guidance documents.
6. [WHO 2019 Water, sanitation and hygiene in health care facilities](#). This guidance document is not specific to COVID-19, but provides practical recommendations to address WASH in maternity wards.
7. [WHO COVID-19 Risk Communication and Community Engagement Technical Guidance](#). This guidance is designed to support risk communication guidance for health care facilities, healthcare workers and for communicating effectively with the public, engaging with communities, local partners and other stakeholders to help prepare and protect individuals, families and the public's health during early response to COVID-19.
8. [UNFPA Coronavirus Disease \(COVID-19\) Preparedness and Response - Interim Technical Brief, March 2020](#). The document contains detailed programmatic guidance and UNFPA operational/support focus. Guidance specifically addresses SRH in general, contraception and related supply, gender equality and gender-based violence considerations and specific considerations for adolescents and young people.
9. [RCOG Coronavirus \(COVID-19\) Infection in Pregnancy. Version 4.1: Published Thursday 26 March 2020](#). This document, written as a reference for clinicians in the UK, provides detailed clinical guidance for the management of pregnant women with COVID-19 infection during pregnancy, delivery and in the immediate post-partum period, particularly in regard to breastfeeding and managing the mother-newborn transmission risk.
10. [RCOG Coronavirus \(COVID-19\) Infection and Abortion Care. Version 1: Published Saturday 21 March 2020](#). This document, written as a reference for clinicians in the UK, provides detailed clinical guidance for the management of abortion for women with COVID-19 infection.
11. [UK Faculty of Sexual and Reproductive Health Care Position on Essential SRH Services during COVID-19](#). This document, written as a reference for health services providers in the UK, outlines guidance on continuity of essential sexual and reproductive health services, including strategies for ensuring access to effective contraception.
12. [Jhpiego Initial Assessment of Clients Presenting for Intrapartum Care: Summary of Key Considerations in the Context of COVID-19 March 2020](#). This easy-to-use job aid walks health care workers through initial assessment of clients presenting for intrapartum care in the context of COVID-19 – from normal rapid assessment for complications in pregnancy to assessment for signs and symptoms of COVID-19.

Issue briefs

13. [UNFPA Statement on novel coronavirus \(COVID-19\) and pregnancy](#). The statement underlines the importance of maintaining access SRH in general and skilled birth attendance specifically, the importance to maintain mother and newborn together and to ensure breastfeeding.

14. [CARE Gender Implications of COVID-19 outbreaks in development and humanitarian settings](#). This document highlights the impact of an epidemic on access to sexual and reproductive health services, as well as implications on women and girls specific to their role in society, as health workers and as care takers at home.

Guidance from past epidemics

15. [WHO Pregnancy and pandemic influenza A \(H1N1\) 2009: Information for programme managers and clinicians](#). July 2010. This document is not specific to COVID, but contains relevant guidance regarding routine sexual and reproductive health services, the mother-newborn dyad, and general maternity infection prevention measures, which are equally applicable to COVID-19.

16. [WHO Reducing excess mortality from common illnesses during an influenza pandemic](#). 2008. This document includes pragmatic guidance regarding sexual and reproductive health services during a pandemic, including what and how to shift to community level services (see page 25 onwards).



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